DISTRICT OF COLUMBIA
Department of Health
Office of Adjudication and Hearings
825 North Capitol Street N.E., Suite 5100
Washington D.C. 20002
(202) 442-9091

DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH Petitioner, v. MULTI-THERAPEUTIC SERVICES, INC. and BENTLEY HAMILTON Respondents	Case Nos.: I-00-40087 I-00-40094

FINDINGS OF FACT, CONCLUSIONS OF LAW AND FINAL ORDER

The Government commenced these consolidated cases by service of Notices of Infraction on February 14, 2000 (Case No. I-00-40087) and March 31, 2000 (Case No. I-00-40094). The Notices of Infraction allege violations of various District of Columbia regulations at two group homes for mentally retarded persons operated by the Respondents. Case No. I-00-40087 concerns alleged violations at a group home located at 6014 32nd Street, N.W. (the "32nd Street Facility"), while Case No. I-00-40094 concerns alleged violations at a group home located at 2852 Northampton Street, N.W. (the "Northampton Facility").

This administrative court held an evidentiary hearing on May 12, 17 and 19, 2000. Based upon the testimony at the evidentiary hearing, my assessment of the credibility of the witnesses, the documents received in evidence,[1] the arguments of counsel and the entire record in this case,

[1] Pursuant to the order of April 13, 2000, the parties pre-filed copies of exhibits that they intended to introduce into evidence. Respondents did not offer all of the pre-filed exhibits, however, and I rejected certain exhibits offered by the Government. The parties also offered additional exhibits during cross-examination and on rebuttal. The exhibits admitted into evidence are Petitioner's Exhibits ("PX") 1, 2, 5, 6, 7, 8, 9, 10, 11 and 12, and Respondents' Exhibits ("RX") 6 and 15.

I make the following findings of fact and conclusions of law.

I. THE 32ND STREET FACILITY

A. Findings of Fact

1. Background

Respondent Multi-Therapeutic Services, Inc. ("MTS") operates a group home for mentally retarded persons at 6014 32nd Street, N.W. Respondent Bentley Hamilton is the Executive Director of MTS. The 32nd Street Facility is a licensed group home for mentally retarded persons. At the time of the events at issue, four mentally retarded adults lived there.

Semret Tesfaye, an inspector employed by the District of Columbia Department of Health, visited the 32nd Street Facility on January 19, 24, 27 and 28, 2000, in connection with an annual recertification survey. As the result of her visits, the inspector believed that she had observed several violations of the regulations found at 22 DCMR Chapter 35.

On February 14, 2000, the Government sent Respondents a Notice of Infraction (NOI 00-40087) concerning the 32nd Street Facility. That Notice of Infraction sought two separate $500.00 fines – one for alleged violations of 22 DCMR 3502, which prescribes requirements for meal service, and one for alleged violations of 22 DCMR 3521, which prescribes requirements for habilitation and training programs. At or about the same time, the Government sent Respondents a Statement of Deficiencies and Plan of Correction form ("PX-1") identifying specific provisions of the regulations that allegedly were violated and providing a statement of

facts supporting the allegations.[2] PX-1, together with the Notice of Infraction, informs the Respondents of the specific violations alleged at the 32nd Street Facility and the Government's version of the facts supporting those allegations.

Respondents did not respond to the Notice of Infraction within the fifteen days required by the Notice and by D.C. Code § 6-2712(e). Instead, Respondents filed an untimely plea of Deny on March 22, 2000, and requested a hearing. On March 24, 2000, the Chief Administrative Law Judge issued an order scheduling a hearing and imposing a statutory penalty of $1,000.00 for Respondents' failure to file a timely response. The order stated that "while Respondents' brief written explanation for their untimely answer is currently insufficient, the Respondents may elect to supplement the record on this point at the scheduled hearing."

Respondents introduced no evidence at the hearing explaining the reasons for their untimely response to the Notice of Infraction.

2. The Meal Service Allegations

The allegations concerning meal service arise from the dinner that was served to the residents of the 32nd Street Facility on January 19, 2000. MTS's registered dietician, Ms. Whitmore, prepares monthly menus for the 32nd Street Facility. She prepares three separate menus for the facility – a general menu and two special menus to meet the specific needs of two residents. To the extent feasible, the three menus feature the same entrée, in order to reduce the

[2] PX-1 alleges violations of regulations other than those in 22 DCMR 3502 and 22 DCMR 3521. Because the Government did not seek a fine for those alleged violations, I have not considered any evidence tending to show other violations at the 32nd Street facility.

burden of preparing three different meals. For weekdays, Ms. Whitmore plans a menu (including snacks) that will satisfy approximately two-thirds of the residents' nutritional needs, as she expects that the food provided at the residents' day programs will satisfy the remaining one-third of those needs.

Facility staff may substitute items for those specified on the menus. Ms. Whitmore prepares a list of acceptable substitutes so that a substituted meal will have the same nutritional value as the meal specified on the menu. The facility staff is required to keep a list of all changes that they make to a prepared menu so that Ms. Whitmore may review those changes.

The facility's general menu for January 19th prescribed a dinner of spaghetti with meat sauce, garlic bread, salad with ranch dressing, butterscotch pudding and grape juice. The meal actually served consisted of two small chicken drumsticks about six inches long, one boiled potato about three inches in diameter, and small portions of peas and corn. The dessert was fruit cocktail and the beverage was water. The residents asked the staff for bread, but did not receive any. There is no evidence that the facility's staff documented the change from the prescribed menu nor is there any evidence that the meal actually served satisfied the requirements of the substitution list that Ms. Whitmore had prepared.

Each of the four residents was served the same meal. Two of them, however, had been prescribed modified diets by physician's order. One resident (Client #1[3]) was prescribed a high fiber diet consisting of "ground" food. Because of the concern that Client #1 needed to gain

[3] To safeguard the privacy of the residents, I will refer to them by the Client Numbers assigned by the Department of Health, Health Regulation Administration.

weight, Ms. Whitmore also had instructed that he was to be served a double portion if he requested it.

Client #1 asked for additional food, but did not receive any. His food was cut into bite-sized pieces, and Respondents contend that this satisfied the requirement that his food be "ground." Ms. Whitmore testified that "ground" was a dietetic term of art meaning that the food should be chopped so that a person could swallow it with little or no effort, and that cutting the food into bite-sized pieces made it "ground". In the absence of contrary evidence I find her testimony on this point to be credible. There is no evidence addressing whether Client #1 received the required high fiber diet on January 19th.

Another resident (Client #3) is diabetic. He had been prescribed a 2000 calorie ADA (American Diabetic Association) diet. In addition, Ms. Whitmore had prescribed that any fruit cocktail served to him should be served only in natural juices, not in syrup, in order to minimize his sugar intake. It is undisputed that Client #3 received fruit cocktail in syrup on January 19th, contrary to Ms. Whitmore's instructions.[4]

During the early evening of January 19th, the facility did not have sufficient food available to meet the requirements of the menu for the next day's breakfast. It is undisputed, however, that the house manager went food shopping that evening, and there is no further

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[4] Client #3 was on a weight reduction diet and has been described as having a "dysfunctional relationship with food". He often engages in inappropriate behavior related to food, including snatching food from others, retrieving it from the trash can, and continually asking for it. Therefore, I give minimal weight to the evidence that he was complaining about the amount of food served on January 19th, as his complaints would not necessarily establish that the meal served was inadequate.

evidence about what food items were served for breakfast on the morning of January 20th. Accordingly, there is no basis for finding any violations with respect to that meal.[5]

3. The Allegations Concerning Habilitation And Training

MTS has adopted individual habilitation plans for each of the residents of the 32nd Street Facility. Those plans state general goals and objectives for each resident to achieve. MTS also has developed individual activity schedules for each resident. Those schedules contain daily activities for each resident and state a time for each activity to occur. The schedules are intended to help ensure that the residents engage in the activities necessary for them to achieve the goals stated in their individual habilitation plans.

MTS does not always follow the daily activity schedules rigidly. Instead, Respondents regard the schedules as guidelines to the staff in implementing the individual habilitation plans. For example, they believe that a client whose habilitation plan called for him to become proficient in passing out snacks might achieve that goal by passing out a night time snack instead of an afternoon snack, even if the activity schedule called for him to pass out the afternoon snack.

Neither party introduced any of the clients' activity schedules or individual habilitation plans into evidence. Ms. Tesfaye, however, testified to the details of the activity schedules.

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[5] There is conflicting testimony about whether the house manager (who was not present at the 32nd Street Facility during the afternoon and evening of January 19th) went shopping only in response to a telephone call from the inspector or whether she already was at the supermarket when the inspector contacted her. That conflict is irrelevant to the issues arising out of the January 19th dinner, and I do not need to resolve it.

Respondents neither objected to nor contradicted that testimony. Accordingly, I credit her testimony about the contents of the clients' activity schedules.

On several occasions during Ms. Tesfaye's visits to the 32nd Street Facility, the individual activity schedules for the clients were not followed. Those occasions are described below.

The activity schedule called for the clients to engage in various activities during the afternoon of January 19th. Client #1 was supposed to pass a snack at 4:30 P.M., but did not do so. Instead, staff members passed the snack. Client #2 was supposed to make a telephone call at 5:00 P.M., but did not do so. Client #4 was scheduled to participate in an arts and crafts activity between 5:00 and 5:30 P.M., but did not do so.

On January 27th, all four residents were scheduled to attend their regular day program. They did not do so because the facility was unable to provide transportation for them. The facility's van was out of service, and had been in that condition for about two weeks. Accordingly, it was not available to transport the clients. The facility's contingency plan is that a van from another group home operated by MTS should pick up the clients and take them to the day program. On January 27th, however, the van from the other group home also was being serviced. Even though MTS operates eleven group homes, it did not have a regular back-up van or any other available means of providing transportation. Facility personnel insisted that January 27th was the only occasion on which both the facility's van and the back-up van from the other facility were unavailable on the same day, but, as noted below, I do not credit that testimony.

Client #3's behavior management plan calls for him not to sit idly for a long period of time. Instead, staff members are supposed to give him opportunities to engage in activities at least every thirty minutes and to give him praise and rewards for his participation. This did not occur while the clients were awaiting transportation on January 27th. The staff did not offer this client any opportunities for activities until 11:25 A.M. At that time, all residents were brought downstairs to play board games, as it was apparent that transportation to the day program was not going to arrive.[6]

When the inspector arrived at the facility on the morning of January 28th, one resident (Client #2) was present at the facility even though he was scheduled to be at a day program. The other three clients attend a different day program to which they had been transported. Client #2 was not picked up until 11:15 A.M. This refutes MTS's claim that January 27th was the only date on which adequate transportation was unavailable to the residents of the 32nd Street Facility. There has been no explanation offered for the delay in transporting Client #2 to his day program on January 28th.

B. Conclusions of Law

1. Notice of the Charges

[6] The testimony is in conflict concerning the residents' activities during the morning of January 27th. Respondents' witnesses testified that the residents did not sit idly, but went downstairs to play board games and engage in other activities throughout the morning. The witnesses, however, were uncertain and inconclusive about when the residents went downstairs. The inspector, by contrast, insisted that they did not go downstairs before 11:25 A.M., and her contemporaneous notes (PX-12) corroborate her testimony. Accordingly, I accept her version of events on the morning of January 27th.

At the start of the hearing, Respondents moved to dismiss the Notice of Infraction concerning the 32nd Street Facility on the ground that they received inadequate notice of the charges against them. I denied that motion for the reasons stated on the record at that time. In light of my disposition of the charges concerning the Northampton Facility, I briefly will supplement my oral ruling that Respondents received adequate notice of the charges concerning the 32nd Street Facility.

The Notice of Infraction charges Respondents with "[f]ailure to comply with the requirements concerning meal service" and "[f]ailure to comply with the requirements concerning habilitation and training". It does not cite specific regulations that Respondents allegedly violated, but simply cites 22 DCMR 3502 for the meal service violations and 22 DCMR 3521 for the habilitation and training violations. The meal service regulations found at 22 DCMR 3502 consist of twenty-one separate subparts and the habilitation and training regulations found at 22 DCMR 3521 contain twelve separate subparts. By themselves, the citations in the Notice of Infraction are not sufficiently specific to inform Respondents of the regulations that they allegedly violated.[7] Respondents, however, obtained that information from another source.

Respondents received PX-1, a Statement of Deficiencies and Plan of Correction form (hereinafter a "Deficiency Statement"), at or about the same time as they received the Notice of

[7] The language used to describe the alleged violations in the Notice of Infraction is similar to that contained in the schedule of fines found in 16 DCMR, Chapter 32. See, e.g., 16 DCMR 3239.2(f), which classifies a violation of any of the provisions of "22 DCMR 3521 (failure to comply with the requirements concerning habilitation and training)" as a Class 2 infraction. Section 3239.2(f), however, does not purport to define what constitutes adequate notice of a violation. It is simply a concise way of saying that a violation of any of the twelve subsections of 22 DCMR 3521 is a Class 2 infraction.

Infraction. The Government's inspectors usually issue Deficiency Statements in cases involving group homes for mentally retarded persons. A Deficiency Statement supplements a Notice of Infraction by supplying necessary details that are not included on the Notice of Infraction form. The Notice of Infraction is designed to be a uniform charging document suitable for use in all of the various types of cases that are within the jurisdiction of this administrative court[8]. It is intended to provide all respondents with certain basic information necessary for them to understand the nature of the case. Due to the space limitations of the form, however, it is not always possible to include a complete statement of the facts constituting the violation, especially where, as here, the relevant facts can not be reduced to a short sentence or two.

A reasonable member of the regulated community who receives both a Notice of Infraction and a Deficiency Statement alleging violations of the same statute or regulation at a specific facility should understand that the Deficiency Statement describes in greater detail the alleged violations charged in the Notice of Infraction. Consequently, the Deficiency Statement ordinarily should be deemed incorporated into the Notice of Infraction, and the specific factual allegations or legal citations in the Deficiency Statement will modify more general statements in the Notice of Infraction.

PX-1 identifies specific provisions of both the meal service regulations and the habilitation and training regulations that Respondents allegedly violated. Taken together, the Notice of Infraction and the Deficiency Statement are sufficient for a reasonable member of the regulated community to understand the specific allegations in this case and to prepare a defense.

[8] Those cases include factually simple claims such as operating a child development center without a license (see 29 DCMR 301.1) or failing to obtain the necessary environmental permits for a construction project (see 29 DCMR 502.1) as well as more complex allegations like the ones at issue here.

Watergate Improvement Associates v. Public Service Commission, 326 A.2s 778, 786 (D.C. 1974) (notice is sufficient if it allows a party adequate opportunity to prepare for hearing). Respondents were not prejudiced in any way by the notice they received concerning the 32nd Street Facility, as they came to the hearing fully prepared to defend against the Government's allegations. Accordingly, there is no basis for dismissing the Notice of Infraction concerning the 32nd Street Facility due to insufficient notice.

2. The Meal Service Allegations

PX-1 cites 22 DCMR 3502.1 as the regulation allegedly violated during the January 19 dinner. That provision requires each group home for mentally retarded persons to "provide each resident with a nourishing, well-balanced diet". At the very least, a "nourishing well-balanced diet" must consist of meals that provide adequate nutrition and does not contain foods that are contraindicated for any or all of the residents. The January 19th dinner fails that requirement, for three separate reasons.

First, the wide variance between the menu and the dinner served is sufficient to support a conclusion that the meal did not provide adequate nutrition to any of the residents. Because MTS's dietician plans menus to ensure that the residents' nutritional needs are being met, it follows that significant variations from those menus are likely not to be sufficiently nutritious. The combination of the variance from the planned menu and the extremely small portions served persuades me that there was a significant difference between the nutritional value of meal on the menu and the meal that actually was served. Respondents' failure to introduce evidence within their control, i.e., either the substitution lists that the dietician had prepared or the change list that

the facility staff should have prepared on January 19th, further supports this conclusion. If that evidence demonstrated that the January 19th dinner supplied adequate nutrition, Respondents would have introduced it.

To be sure, in a close case the Government may need expert testimony to establish that a particular meal did not satisfy residents' nutritional needs. This is not a close case, however. Ordinary human experience teaches that two small chicken drumsticks, one extremely small potato and some vegetables are not as nutritious as the full spaghetti dinner, including meat sauce, salad, garlic bread and grape juice, that was planned for January 19th. Thus, Ms. Tesfaye properly offered a lay opinion on that issue, based upon her contemporaneous observations. *Carter v. United States,* 614 A.2d 913, 919 (D.C. 1992) (non-expert witnesses may offer opinion based on the witness' observation of events if the opinion is helpful to the fact finder); see also Fed R. Evid. 701. Ms. Tesfaye's opinion, along with the other evidence and the negative inference from Respondents' failure to introduce potentially exculpatory evidence in their possession, supports the conclusion that the January 19th dinner was not "nourishing" or "well-balanced" as required by the regulation.

Second, the facility's refusal to serve an extra portion to Client #1, who was on a weight-gain diet, is an independent violation of 22 DCMR 3502.1. Here again, I rely upon the diet prescribed by the facility's own professionals. They believed it was necessary for this resident to gain weight, but the dinner he received on January 19th was inconsistent with that goal. It did not

provide him with the nourishment that MTS itself believed he should receive and, therefore, was not "nourishing" or "well-balanced" as required by the regulation.[9]

Finally, serving fruit cocktail in syrup to Client #3, a diabetic, was directly contrary to the explicit instructions of MTS's dietician. A meal that unnecessarily increases a diabetic's sugar intake scarcely can be called "nourishing and well-balanced."

The Government has sought a $500.00 fine for a single violation of 22 DCMR 3502.1 on January 19th, even though the evidence is sufficient to establish the three separate violations identified above. I will impose the $500.00 fine requested.

2. The Habilitation and Training Allegations

The Government also contends that the deviations from the residents' activity schedules that occurred on January 19, 27 and 28 violate 22 DCMR 3521.3. It did not charge Respondents with violating 22 DCMR 3521.11, which requires that a resident's activity schedule "shall be available to direct care staff and be carried out daily." Instead, the only applicable regulation cited in PX-1 is 22 DCMR 3521.3, which requires Respondents to provide "habilitation, training and assistance to residents in accordance with the resident's Individual Habilitation Plan."[10]

[9] As noted above, based on the testimony in the record, the meal did comply with the physician's requirement that it be "ground". There is insufficient evidence to determine whether it met the requirements of a high fiber diet.

[10] The discussion of "Habilitation and Training" in PX-1 alleges violations of other regulations. The Government introduced no testimony or other evidence concerning those allegations. Accordingly, I have not considered those claims.

Section 3599 of 22 DCMR incorporates the definition of "habilitation" found in D.C. Code § 6-1902. The D.C. Code defines "habilitation" as:

> "the process by which a person is assisted to acquire and maintain those life skills which enable him or her to cope more effectively with the demands of his or her own person and of his or her own environment and to raise the level of his or her physical, intellectual, social, emotional and economic efficiency. 'Habilitation' includes, but is not limited to, the provision of community-based services."

D.C. Code § 6-1902(14).

Section 3521.3, therefore, requires group homes to provide residents with assistance and training in acquiring and maintaining various life skills, as called for in their individual habilitation plans. Individual habilitation plans must contain, among other things, appropriate intermediate and long-term goals, a plan for achieving those goals and an evaluation procedure and schedule for determining whether the goals are being achieved. D.C. Code § 6-1943(c). See 22 DCMR 3599 (incorporating the D.C. Code definition of "Individual Habilitation Plan" into the regulations). Although no party introduced either the individual habilitation plans or the activity schedules for the clients of the 32nd Street Facility, the evidence is sufficient to determine that there have been deviations from those plans.

There is no dispute that certain activities specified in the residents' activity schedules did not take place on the days in question. By charging Respondents with a violation of 22 DCMR 3521.3, however, the Government has undertaken the additional burden of proving that those deviations from the schedule constitute a failure to "provide habilitation, training and assistance in accordance with the resident's Individual Habilitation Plan." Although the individual habilitation plans are not in evidence, the testimony is unrebutted that Respondents regard the

activity schedules as guidelines for the implementation of the Individual Habilitation Plans.[11] It is a reasonable inference, therefore, that continued or repeated failure to follow the activity schedules is a failure to provide residents with assistance in meeting the goals of their individual habilitation plans in violation of § 3521.3. That inference is not an irrebutable presumption, however. Evidence that activities similar to those called for in the activity schedule took place or that the scheduled activities took place at some other appropriate time would demonstrate that the residents were receiving appropriate habilitation even if the activity schedules were not followed.

The evidence is sufficient to establish that Respondents repeatedly failed to follow the activity schedules that they had devised for the residents of the 32nd Street Facility. On January 19th, scheduled afternoon activities for three clients (passing a snack, making a telephone call, and engaging in arts and crafts) did not occur and nothing was substituted for those activities.[12] The failure to arrange transportation for all of the clients to the day program on January 27th is another example of failure to conform to the activity schedule. MTS's plan for alternate transportation was inadequate, and the clients were not offered any substitute activity for at least three hours that day. The facility's staff also acted contrary to the established behavioral plan for Client #3 when they permitted him to sit idle for most of the morning of January 27th.

[11] Because the Government has not charged Respondents with violating § 3521.11, I have no occasion to decide whether, as Respondents believe, strict compliance with activity schedules is not required. Nothing in this opinion necessarily should be construed as holding that Respondents or any other group home operators are free to deviate at will from the activity schedules they have prepared.

[12] Respondents offered testimony that Client #1 could have passed a snack in the evening instead of in the afternoon as called for by the activity schedule. That evidence does not prove that he did so. Moreover, Respondents offered no evidence that Client #2 made a telephone call at some other time or that Client #4 worked on an arts and crafts project at another time.

Respondents also did not transport Client #2 to his day program on the morning of January 28th and they offered him no substitute activity.

The evidence establishes that Respondents repeatedly failed to follow the schedules that they themselves prepared and that they did not provide substitutes for the scheduled activities. Those failures violate the requirement of 22 DCMR 3521.3 that Respondents provide "habilitation, training and assistance to residents in accordance with the resident's Individual Habilitation Plan." Accordingly, I will impose the $500.00 fine sought by the Government for this violation.

3. Timeliness of the Response

Respondents' untimely response to the Notice of Infraction for the 32nd Street Facility requires the imposition of a penalty equal to the amount of the total fine sought, unless Respondents can show good cause for their failure to respond in a timely fashion. D.C. Code §§6-2704(a)(2)(A), 6-2712(f). Because Respondents have offered no evidence to explain their untimely response to the Notice of Infraction, there is no basis for suspending or reducing the $1,000.00 statutory penalty for late filing that was assessed by this administrative court's order of March 24, 2000.

II. THE NORTHAMPTON FACILITY

A. Findings of Fact

MTS operates a separate licensed group home for mentally retarded persons at 2852 Northampton Street, N.W. Five adults lived there at the time of the incidents at issue.

On the evening of January 26, 2000, the residents were restless and did not go to sleep on time. Staff members later told Ms. Tesfaye that the nurse assigned to distribute evening medications had not come to the facility that night, possibly because of poor traveling conditions due to snow. Although the evidence is in conflict over whether the residents received their medication that night, I find that they did not. I give greater weight to the consistent statements of the facility's staff members to the inspector than I do to the testimony that the facility's log states that medications were distributed, particularly since the log was not introduced into evidence and there was no testimony from the nurse that she did distribute the medicine on the evening in question. Moreover, the lack of medication may explain the restlessness of the residents on that evening.

Between 12:15 and 12:30 A.M. on January 27th, staff members heard a loud noise in the bedroom shared by Client #1 and Client #2.[13] When they went upstairs to investigate, they discovered Client #1 lying on the floor and Client #2 standing over him. Client #1 is non-verbal, so the staff was unable to ask him what had happened.[14] Client #1 was unwilling to remain in his bedroom thereafter. He stayed in the living room for the rest of the night and did not sleep. The staff members on duty suspected that Client #2 had assaulted Client #1. They did not, however, notice any marks or scratches on Client #1 during the night.

[13] The parties have referred to the residents of the Northampton Facility as Clients #1 through #5. Although they used a similar numbering system (Clients #1 through #4) to identify the residents of the 32nd Street Facility, the context will make clear whether a particular client is a resident of 32nd Street or Northampton.

[14] There is no evidence about Client #2's verbal abilities and no evidence of any efforts made by the facility's staff to ask him what had happened.

The night staff also bathed and dressed Client #1 on the morning of January 27th. None of them noticed any marks or scratches on him.[15] A short time later, however, the day staff came on duty and the nurse arrived to distribute morning medications. Both the day staff and the nurse noticed several scratches on Client #1's head, face and shoulders.

Client #1's behavior continued to be somewhat abnormal for the next few days. He tended to follow staff members around and did not want to go to his bedroom. He slept on the living room couch for a few days after the incident. On January 28th, the facility's Qualified Mental Retardation Professional ("QMRP") sent him to the emergency room, based upon concern that he might have been sexually assaulted by Client #2.[16] The emergency room staff described Client #1 as frightened, but found no evidence of sexual assault. On his return from the emergency room, Client #1 remained lethargic and unwilling to sleep in his bedroom.

The evidence suggests two possible causes for the scratches on Client #1. One possibility is that Client #2 assaulted him in their bedroom during the night of January 26-27. Evidence supporting that theory includes the loud noise, Client #2's standing over Client #1 immediately

[15] There is a conflict in the evidence over whether or not the Client #1 was bathed in the dark (either regularly or, at the very the least, on the morning of January 27th) because the light in the bathroom was not working. In light of my disposition of the charges regarding the Northampton facility, it is not necessary to resolve that conflict.

[16] The facility's concern about possible sexual assault arose out of an incident that had occurred one year earlier involving Client #2 and another resident of the Northampton Facility. The staff members on duty on January 27 and 28 believed that the earlier incident had been a sexual assault, but there is no evidence that any of them witnessed the incident and no evidence of the basis for their belief. The facility's psychologist described the incident as one of physically intimate contact that was not necessarily sexual. There was no further testimony about this earlier incident and there is insufficient evidence for me to make any findings about what happened at that time.

thereafter, Client #1's reluctance to return to his bedroom and the failure of Client #2, who suffers from a psychotic disorder, to receive his medication.

The other possibility is that the scratches were self-inflicted, perhaps after Client #1 was bathed and dressed on the morning of January 27th. Record evidence supports that theory as well. For example, it is undisputed that Client #1 had been prescribed medication for a dry skin condition and that his fingernails were long (up to ½ inch) and jagged on the morning of January 27th and for several days thereafter. No staff member at the Northampton Facility had cut his nails because that was the nurse's duty. If Client #1 scratched himself after being bathed and dressed, it would explain why the night staff did not see any scratches. The loud noise and Client #2's standing over Client #1 could be explained by Client #1's falling out of bed, and Client #2's efforts to assist him, especially since, in the past, these two clients had an amicable relationship.[17] Client #1's unwillingness to return to his bedroom is ambiguous, because it can be explained either by fear of Client #2 or by fear of falling out of bed again.

I find the evidence that the scratches were self-inflicted to be more persuasive, although the matter is not free from doubt. Taken together, Client #1's skin condition, his failure to receive medication for it and his untrimmed and jagged nails make it more likely that he scratched himself, especially in the absence of any eyewitnesses to an assault.

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[17] MTS's psychologist testified that she would have expected Client #2 to try to help Client #1 if he fell out of bed.

Both clients remained in the Northampton Facility while the incident was being investigated. They remained assigned to the same bedroom for several days after the incident, although Client #1 was unwilling to go to the bedroom and slept in another room.

MTS filed an unusual incident report on February 2, 2000, and Ms. Tesfaye was assigned to investigate the matter. On March 17, 2000, after completing her investigation, she issued a Notice of Infraction (NOI 00-40094) to Respondents, charging them with a violation of 22 DCMR 3523.1. The Notice of Infraction described the nature of the offense as "[f]ailure to protect one client from abuse (see attached), and Title 19 CFR 483.420."

When she signed the Notice of Infraction, Ms. Tesfaye attached to it a ten-page Deficiency Statement (PX-2). She did not mail the Notice directly, but forwarded it through appropriate channels within the Department of Health for processing. Respondent Hamilton testified that nothing was attached to the Notice of Infraction when he received it, and I credit that testimony. Respondents produced the envelope in which the Notice of Infraction was enclosed (RX-15). It was an ordinary business envelope and was too small to hold the ten-page Statement of Deficiencies. There is no doubt that Respondents received the Statement of Deficiencies at some time, but it was not attached to the Notice of Infraction.

B. Conclusions of Law

Respondents allege that they did not receive adequate notice of the charges concerning the Northampton Facility. Their challenge is well taken.[18]

In order to properly charge Respondents with a violation, the agency must satisfy the notice requirements of the District of Columbia Administrative Procedure Act (the "DC APA"), the Civil Infractions Act and the Due Process Clause of the Fifth Amendment. The evidence establishes that the notice in this case did not comply with either the DC APA or the Civil Infractions Act. Accordingly, I need not consider Respondents' arguments that the notice also was insufficient under the Due Process Clause.

The DC APA requires an agency to give the parties notice of the "issues involved" in a contested case. D.C. Code § 1-1509(a). Similarly, the Civil Infractions Act requires a Notice of Infraction to contain a "citation of the law or regulation alleged to have been violated," as well as a statement of the "nature, time and place of the infraction." D.C. Code § 6-2711(b)(2), (3). Simply put, an agency seeking to penalize a party for a statutory or regulatory violation must inform that party of the statute or regulation allegedly violated as well as the underlying facts that constitute the alleged violation.

To be sure, under the DC APA, a defect in a hearing notice is not necessarily fatal to an agency's claim against an adverse party. An agency may proceed even in the face of defective notice if the adverse party "was given adequate opportunity to prepare and present its position

[18] As with the charges concerning the 32nd Street Facility, Respondents moved to dismiss the Northampton charges at the outset of the hearing. I originally denied that motion, but reconsidered my ruling and reserved decision in light of the arguments and evidence put forward by Respondents.

. . .and . . . no prejudice resulted from the originally deficient notice." *Watergate Improvement Associates v. Public Service Commission,* 326 A.2d 778, 786 (D.C. 1974). See also *Ridge v. Police & Firefighters Retirement and Relief Bd.*, 511 A.2d 418, 424 (D.C. 1986).[19]

Measured against these standards, the notice of the charges concerning the Northampton Facility was inadequate. In particular, Respondents were left to guess about what law or regulation the Government believed had been violated. The regulation cited in the Notice of Infraction – 22 DCMR 3523.1 – is an extremely broad provision. It requires operators of group homes for mentally retarded persons to "ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter [i.e., 22 DCMR Chapter 35], and other applicable District and federal laws." By itself, § 3523.1 does not create any substantive rights. It simply requires persons in Respondents' position to observe and protect the rights granted to residents by other laws and regulations. In order to violate § 3523.1, therefore, a group home operator must have violated some other requirement of federal or District of Columbia law. It follows that a Notice of Infraction that charges only a violation of § 3523.1 is defective under the DC APA (because it does not notify the Respondents of the issues involved), and under the Civil Infractions Act (because it does not inform the Respondents of the specific provision of law they allegedly violated).

[19] Respondents argue that the Civil Infractions Act does not require a showing of prejudice if the Notice of Infraction is inadequate. They rely upon D.C. Code § 6-2711(c), which states that the administrative law judge or attorney examiner "shall enter an order dismissing the notice of infraction" if the notice is defective on its face. (Emphasis added.) As discussed below, the lack of notice in this case was prejudicial, so it is not necessary for me to decide whether Respondents' argument is correct.

Portions of the Notice of Infraction other than the citation to 22 DCMR 3523.1 conceivably could have provided adequate notice in this case, but they did not do so. Although the notice cites "Title 19 CFR 483.420," no such section of the Code of Federal Regulations exists. That citation, therefore, did not notify Respondents of the violation alleged. The citation is probably an attempted reference to Title 42 CFR 483.420, but even if so interpreted, it is unavailing to the agency. That section sets forth, in more than twenty subsections, a broad range of rights afforded to residents of certain facilities for the mentally retarded, including privacy rights, visitation rights and rights concerning personal property and finances. A mere allegation that a party has violated 42 CFR 483.420, without further specification of the resident's right at issue, is insufficient to provide adequate notice of the agency's claim against that party.

The Notice of Infraction also states "see attached", which is a reference to PX-2, the Deficiency Statement that the inspector prepared with respect to the Northampton Facility. That document, however, was not attached to the Notice of Infraction that was served on Respondents. As noted in the discussion of the 32nd Street Facility, see pp. 10-11 supra, a Deficiency Statement ordinarily will be deemed to be incorporated into a Notice of Infraction. Thus, even though PX-2 was not physically attached to the Notice of Infraction, I may consider it in determining whether Respondents received adequate notice of the charges concerning the Northampton Facility.

PX-2 does not satisfy the Government's burden of providing Respondents with notice of the charges against them. Although the portion of the document that deals with the alleged violation of § 3523.1 (pages 5-10) sets forth a comprehensive description of the investigation of

the incident and the investigator's factual conclusions, it does not inform Respondents of the specific legal rights of Client #1 that allegedly were violated, and does not identify any regulation other than § 3523.1 that Respondents allegedly violated.

This administrative court's pre-hearing order, issued April 13, 2000, provided another opportunity for the Government to cure the notice problem. That order required the Government to file and to serve upon Respondents a copy of any statute or regulation upon which it would rely to prove a violation of § 3523.1. The Government did not file any such statute or regulation. Its failure to do so, coupled with the deficiencies described above, left Respondents and this court in the dark about the specific rights it was claiming had been violated.

The lack of notice prejudiced Respondents' defense of this case. Although Respondents recognized that the events surrounding the appearance of the scratches on Client #1 were the focus of the allegations concerning the Northampton Facility, they never received a clear statement identifying the specific law or regulation that they allegedly violated. Moreover, the Government's factual theories shifted during the course of the hearing. PX-2 concludes that Respondents had failed to protect Client #1 from abuse "by a staff or by another client . . . " PX-2 at 5. At the hearing, however, counsel for the agency argued that the conflict in the evidence over the cause of the scratches made no difference, because Respondents had violated § 3523.1 even if the scratches were self-inflicted.[20] It is well established that such a fundamental shift in an agency's theory of the case during a hearing prejudicially deprives the adverse party of adequate notice of the charges against it. *Transportation Leasing Co. v. Department of*

[20] It may be that provisions of District of Columbia or federal law can be cited to support that assertion, but neither Respondents nor this administrative court had notice of them.

Employment Services, 690 A.2d 487 (D.C. 1997); *Amalgamated Meat Cutters v. NLRB*, 663 F.2d 223, 227-229 (D.C. Cir. 1980).

Because Respondents did not receive proper notice, the Notice of Infraction for the Northampton Facility must be dismissed. Dismissal of the charge, however, should not be construed in any way as approval of Respondents' actions concerning this incident. As noted above, the preponderance of the evidence persuades me that the scratches were self-inflicted. The record is devoid of any explanation why the facility's staff allowed the fingernails of Client #1 (who suffered from a dry skin condition and therefore was likely to scratch himself) to grow too long and to become jagged. Nor have Respondents offered any explanation why Client #1's fingernails were not cut for at least several days after the scratches first appeared. I do not necessarily question Respondents' policy that a nurse must cut the residents' fingernails. Respondents, however, must make sure that important health-related tasks are accomplished in a timely manner regardless of to whom they have assigned those duties. This is especially critical for residents like Client #1 who are unable to care for themselves, or, indeed, to communicate their needs.

III. ORDER

Based upon the foregoing findings of fact and conclusions of law, it is hereby, this _____ day of _____ 2000:

ORDERED, in Case No. I-00-40087 that Respondents shall pay a fine of $500.00 for violating 22 DCMR 3502.1; and shall pay a fine of $500.00 for violating 22 DCMR 3521.3; and it is further

ORDERED, in Case No. I-00-40087 that Respondents shall pay a statutory penalty of $1,000.00 for failing to file a timely response to the Notice of Infraction; and it is further

ORDERED, that Case No. I-00-40094 is **DISMISSED**; and it is further

ORDERED, that Respondents shall cause to be remitted a single payment totaling **TWO THOUSAND DOLLARS ($2,000.00)** in accordance with the attached instructions within twenty (20) calendar days of the date of mailing of this Order (fifteen (15) calendar days plus five (5) days for service by mail pursuant to D.C. Code § 6-2715). A failure to comply with the attached payment instructions and to remit a payment within the time specified will authorize the imposition of additional sanctions, including the suspension of Respondents' license or permit pursuant to D.C. Code § 6-2713(f).

/s/ 6/26/00

John P. Dean
Administrative Judge